

Case Summary. Patient was started on immune suppression (mycophenolate and steroids)

At 6 monthly follow up, she was free of angina

Plan of further peripheral intervention soon (right subclavian and bilateral renal arteries)

Coronary involvement in Takayasu arteritis varies from 10-18%, but in this age group and presenting with angina is very rare, and a complex intervention for the same is even rarer. Probably this is the first such case in literature.

Covered stent was used since, in our center, the restenosis rates were low when using covered stents in aorto-ostial lesions.

TCTAP C-065

Usefulness of Glider Balloon for Percutaneous Coronary Intervention to the Bifurcation Lesion by Culotte Stenting

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[CLINICAL INFORMATION]

Patient initials or identifier number. K. T

Relevant clinical history and physical exam. This is 50's female known history of diabetes mellitus, hypertension and dyslipidemia. She underwent for percutaneous coronary intervention (PCI) to left anterior

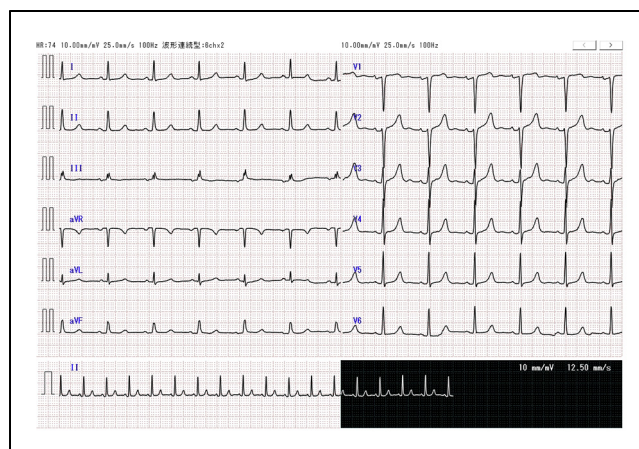
descending artery (LAD) for Angina pectoris on June 2011. She had been taken the hemodialysis (HD) for end stage renal failure due to diabetic nephropathy from August 2013. She complained of chest pain during HD from November 2013.

Relevant test results prior to catheterization. Her blood test showed that end stage renal failure.

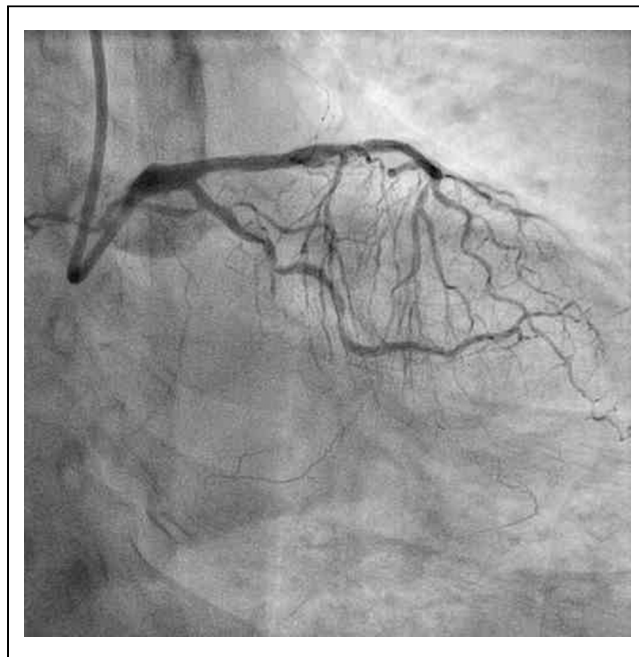
Her ECG showed normal sinus rhythm, non Qwave, no significant ST-T change.

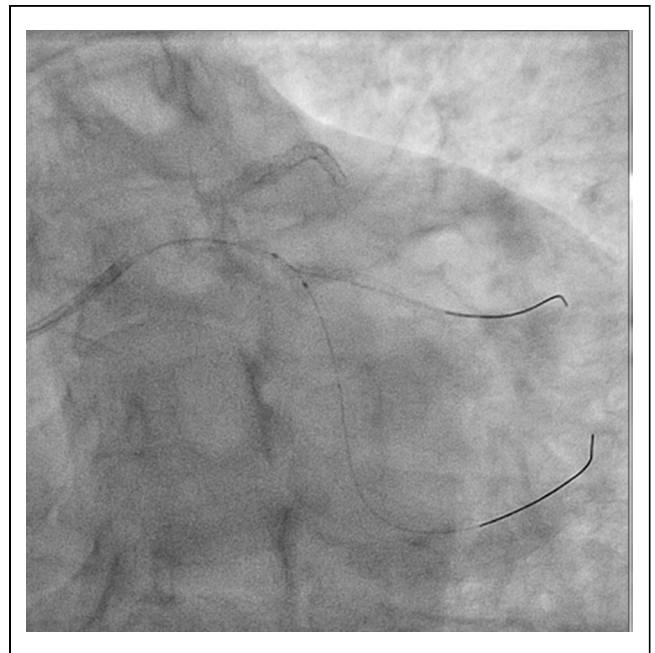
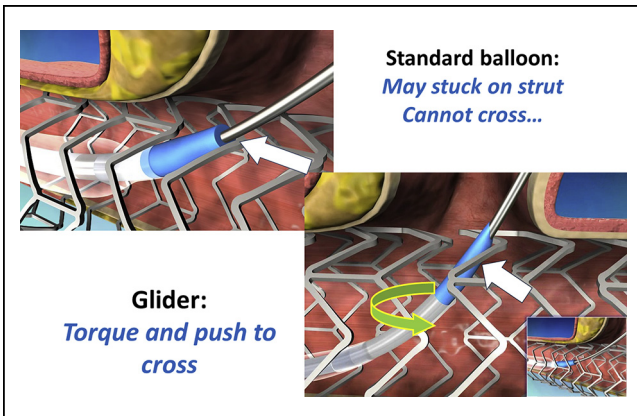
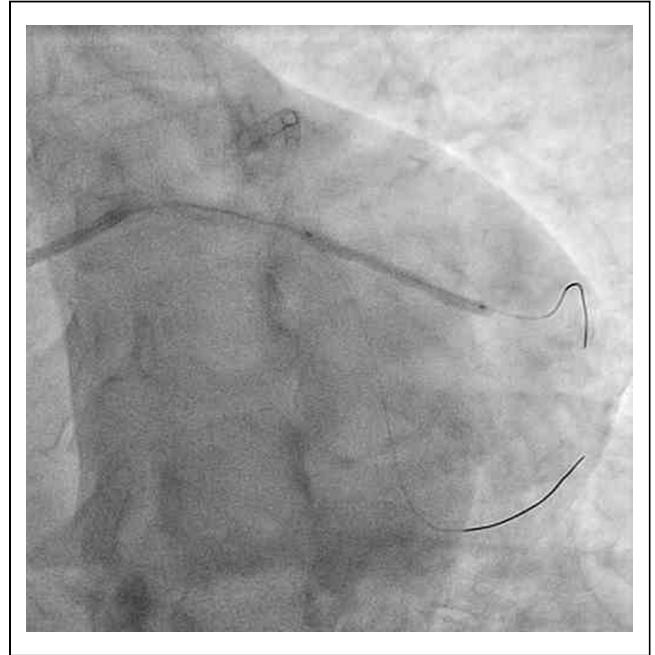
Chest X-ray showed that CTR was 50%, no pleural effusion and congestion.

Her UCG showed no asynergy, good left ventricular systolic function and no valvular disease.



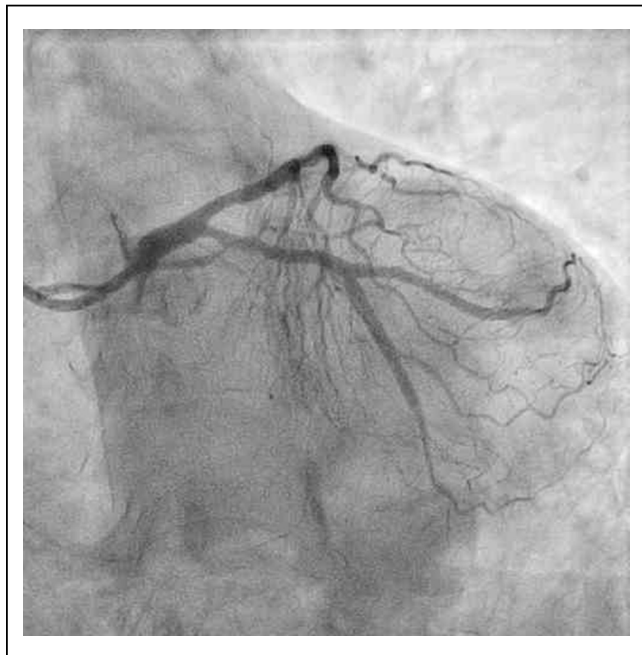
Relevant catheterization findings. We performed coronary angiogram (CAG) on November 2013. It showed that there was no significant stenosis in right coronary artery (RCA) and LAD, chronic total occlusion (CTO) in mid circumflex (Cx) and tight stenosis in obtuse marginal (OM) branch bifurcation. She underwent for PCI to Cx CTO and OM branch bifurcation lesion.





[INTERVENTIONAL MANAGEMENT]

Procedural step. We inserted 6F sheath from right brachial artery. We used EBU3.5 6F guiding catheter. The SION wire and Corsair 135cm micro catheter pass through to Cx CTO lesion. We opened the lesion by 1.25mm & 2.25mm balloon. After open the Cx, we opened the 2.25mm balloon to the OM branch also. After ballooning both arteries were dissected. So we decided the 2 stent strategy. We implanted DES 2.25mm from proximal Cx to OM branch first. Then we tried to open the stent strut (SS) with 2.25mm balloon, but it couldn't pass through to the SS, even the 1.25mm balloon also. So we used the Glider 2.0mm balloon. It could pass through to the SS easily. We could open the SS with the Glider2.0mm balloon. Then we implanted DES 2.5mm to Cx. After deployed the stent, the 2.25mm balloon could not pass through to the SS. Then we used the Glider2.0mm balloon again, it could pass through to the SS. Finally we performed the KBT with 2.5mm and 2.25mm balloon between Cx and OM branch. We could get good blood flow in both arteries.



Case Summary. It is necessary to perform KBT for treatment of bifurcation lesion by the culotte stenting. The KBT requires crossing strut of a previously deployed stent with a wire and balloon, which is unsuccessful in 5-15% cases mainly because the balloon tip hits a SS. The Glider balloon is a dedicated balloon designed for crossing through struts of main branch. The tip shape of it is an oblique cut and can be rotated. We experienced the culotte stenting case that could bail-out with the Glider balloon. It could pass through to the SS even the small profile balloon couldn't do it. The Glider is the bail-out device which offers an effective rescue strategy for recrossing SS during culotte stenting.

TCTAP C-066

The Most Worried Case in the Year: The Treatment Strategy with LCX Ostium Lesion

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[CLINICAL INFORMATION]

Patient initials or identifier number. CBL

Relevant clinical history and physical exam. Male, 70 years old

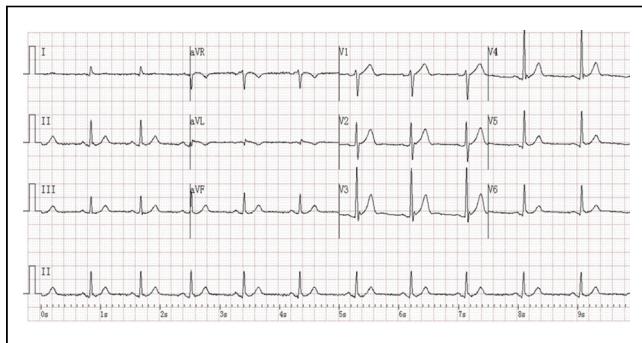
Chief complaint: Recurrent chest discomfort and chest pain in 2 years, worsen in 2 weeks

Coronary risk factor: Hypertension for ten years, and smoking for 20 years

Physical examination: No abnormal examination

Lab Examination: Myocardial biomarkers: normal

Echocardiogram: norm



Relevant test results prior to catheterization. No

[INTERVENTIONAL MANAGEMENT]

Procedural step. 7F EBU 3.5 was engaged in LCA 0.014" Runthrough was advanced to LAD and Fielder was navigated to LCX

MEDINA of LCX subtype (0,0,1)

There is lesion in the proximal and distal segment of LM

The FFR < 0.79 in LCX, and the lumen area less than 2.4mm² in the proximal, and there is dissection in the proximal, which indicated unstable lesion.

Although the plaque seemed to be unstable, but the lumen area is large enough and the FFR > 0.80

3.0mm*15mm balloon(8atm*5s) was predilated, and 3.0mm*30mmDES was deployed to LM-LCX

The wire in LCX was pulled out to rewire in LAD, and the wire in LAD was rewired to LCX

We used 3.0mm*15mm NC and another 3.0mm*15mm NC Balloon to Kiss the stent(10atm*5s)

There is immediate thrombosis in the stent of LCX to LM, and there is a hazy lesion in the polygen Run through is rewired to LAD with Crusade double hole catheter

Repeat post dilatation & aspiration

